

Newborn Hearing Screening & CCHD Results

Baby's Name: _____ Date of Birth: _____ Sex: _____

Hospital or location of baby's birth: _____

Screening agency or site where this test was completed:

Agency: _____ Address: _____

Screeener: _____ Phone: _____

Hearing Screening Results:

_____ **Initial Screening** _____ **Follow-up Screening (screen both ears)**

Technology: _____ TEOAE _____ DPOAE _____ AABR _____ ABR

Date of Testing: _____

Right Ear: _____ PASS _____ REFER **Left Ear:** _____ PASS _____ REFER

Recommendations: _____

Referred to: _____ Date: _____

CCHD Screening Results:

	Date	Time	R Hand	Foot	Result
1 st					Pass Fail Rescreen
2 nd					Pass Fail Rescreen
3 rd					Pass Fail Rescreen

Not Screened Reason:

Echo Date & Time (if applicable):

Parent or Guardian Contact Information:

Name: _____ Address: _____

Phone: _____

Baby's Primary Care Provider:

Name: _____ Phone: _____

I hereby give my permission to staff at the above-named agency or site to release hearing screening results to the hospital where my baby was born and to the Utah Department of Health. I understand that newborn hearing screening is required by law (Utah Code 26-10-6 and R398-2), and must be reported to the Utah Department of Health. The information will be used to ensure that appropriate referral / follow-up services, when necessary, are made available to my child. I understand that this information will not be shared with unauthorized people.

Signature of Parent

Date

To the screening agency:

Please complete this entire form and return copies to our office and to the **birthing hospital** listed, in care of the Newborn Nursery Hearing Screening Coordinator, when applicable:

Fax: (801) 536-0492

Email: EHDI@utah.gov